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BRIEFING PAPER

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NHS maximum waiting times standards and patient choice policies

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Summary

This briefing describes policies on NHS maximum waiting time standards and patient choice.

As set out in the *NHS Constitution*, patients have the right to a maximum 18 week waiting time from referral to consultant-led treatment. Patients also have the right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

The *NHS Constitution* also provides a series of pledges on maximum waiting times for services such as diagnostic tests, A & E, and treatment for diagnosed cancer. Such pledges are not legally binding but represent a commitment by the NHS to provide high quality services. In September 2015, the Government pledged to introduce a new four week waiting time standard for cancer diagnosis by 2020.

The Coalition Government introduced the first maximum waiting time standards for mental health treatment, from April 2015. The standards are for most patients referred for talking therapies to receive treatment within 6 weeks, with a maximum wait of 18 weeks, and at least 50 per cent of people who experience their first episode of psychosis to receive treatment within two weeks of referral. A waiting time standard for children and young people with an eating disorder was also introduced in July 2015. NHS England is currently leading work on the development of further access and waiting time standards for children's mental health.

The Government and NHS England are also working to improve patient choice within the NHS, which is a legal right as set out in the *NHS Constitution*.

Patients have a right to choose their provider and consultant-led team when they are referred for their first outpatient appointment with a service led by a consultant. These rights were for the first time extended to mental health services in April 2014, to embed parity of esteem and bring patients' rights in mental health in line with those for physical health. There are some exceptions to this right, including for people detained under the *Mental Health Act 1983*.

To further strengthen patient choice, a legal right to have a personal health budget was introduced for adults receiving NHS Continuing Healthcare and children and young people receiving Continuing Care in October 2014. The *NHS Mandate 2014-15* also set an objective for the NHS to further roll out personal health budgets to anyone who could benefit, by April 2015.

This briefing applies to England only, although brief information on waiting time standards in the devolved administrations is provided.

1. Maximum waiting time policies

The Department of Health states that all patients should receive high-quality care without any unnecessary delay.[1]

This is emphasised in the Government's *Mandate to NHS England 2015-16*, which sets out that timely access to services is a critical part of people's experience of care.[2]

1.1 Patient rights to maximum waiting times

The *NHS Constitution* provides that patients have a right to certain NHS treatment within maximum waiting times:

> You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible.[3]

The source of these rights is part 9 of the *National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012*, as amended.

The maximum waiting time standards are outlined below:

> You have the right to:
>
> - start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions; and
> - be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.[4]

The 18 week waiting time target from referral to consultant-led treatment was first introduced in June 2004 as part of a series of measures introduced by the Labour Government to reduce hospital waiting. The 18 week measure was originally devised as an ambition to be achieved by 2008, but then remained as an ongoing target.[5]

If it is not possible for treatment to be provided within the current maximum waiting times, the Clinical Commissioning Group (CCG) or NHS England, depending on the type of treatment, must take all reasonable steps to offer an alternative provider, or a range of suitable alternative providers, that would be able to provide treatment more quickly than the provider to which the patient was initially referred. The patient will need to contact either the provider they have been referred to or their local CCG before alternatives can be investigated. The CCG or NHS England must take all reasonable steps to meet their request.

There are certain exceptions to the right to treatment within maximum waiting times:

> In particular, the right to treatment within 18 weeks from referral will cease to apply in circumstances where:
>
> - you choose to wait longer;

1 Department of Health, The handbook to the NHS Constitution for England, July 2015, page 34
2 Department of Health, A mandate from the Government to NHS England: April 2015 to March 2016, page 21
3 NHS, The NHS Constitution for England, July 2015, page 6
4 Department of Health, The handbook to the NHS Constitution for England, July 2015, page 31
5 Journal of the Royal Society of Medicine, Can the English NHS meet the 18-week waiting list target?, January 2006

- delaying the start of your treatment is in your best clinical interests, for example where smoking cessation or weight management is likely to improve the outcome of the treatment;
- it is clinically appropriate for your condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage;
- you fail to attend appointments which you had chosen from a set of reasonable options; or
- the treatment is no longer necessary.[6]

Certain services are also exempt from maximum waiting time standards. These are:

- mental health services that are not consultant-led;
- maternity services; and
- public health services provided or commissioned by local authorities.[7]

1.2 Pledges on waiting times

The *NHS Constitution* also contains "pledges" for the NHS to achieve maximum waiting times. These pledges are not legal rights; the Department of Health states that "the pledges are not legally binding and cannot be guaranteed for everyone all of the time, because they express an ambition to improve, going above and beyond legal rights.[8]

The pledges for maximum waiting times are outlined below:

There are a number of government pledges on waiting times, including:

- a maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers;
- a maximum 31-day wait for subsequent treatment where the treatment is surgery;
- a maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy;
- a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen;
- a maximum two month (62-day) wait from urgent referral for suspected cancer to first treatment for all cancers;
- a maximum 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer;
- a maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers);
- a maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected;

6 Department of Health, The handbook to the NHS Constitution for England, July 2015, page 33
7 Department of Health, The handbook to the NHS Constitution for England, July 2015, page 33
8 Department of Health, The handbook to the NHS Constitution for England, July 2015, page 4

- a maximum four-hour wait in A&E from arrival to admission, transfer or discharge;

- patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral; [there are 15 key diagnostic tests covered in this pledge, including audiology assessments; non-obstetric ultrasounds and cystoscopy[9]]

- a maximum 7 day wait for follow-up after discharge from psychiatric in-patient care for people under adult mental illness specialties on Care Programme Approach.

- all patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice; and

- all ambulance trusts to respond to 75 per cent of Category A calls within eight minutes and to respond to 95 per cent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

- In addition, local authorities with public health responsibilities should bear in mind that it is best practice for the care of patients and their sexual partners to offer genito-urinary medicine appointments as soon as possible, and that the clinical evidence indicates a maximum of 48 hours.[10]

1.3 Waiting time standards for mental health services

In October 2014, the Government announced the first waiting time standards for mental health services, to bring waiting times for mental health in line with those for physical health.

From April 2015, patients should access talking therapy treatment within 6 weeks, with a maximum wait of 18 weeks. For patients experiencing a first episode of psychosis, access to early intervention services should be available within two weeks.

The percentage of patients expected to receive treatment within these targets is below:

> From 1 April 2015 (to be fully implemented by April 2016), the new waiting time standards will be as follows:
>
> 75% of people referred for talking therapies for treatment of common mental health problems like depression and anxiety will start their treatment within 6 weeks and 95% will start within 18 weeks
>
> at least 50% of people going through their first episode of psychosis will get help within 2 weeks of being referred: the aim is to increase this percentage in future years.[11]

This is supported by an £80 million funding package for 2015-16 from NHS England's budgets, breaking down as:

- £40 million recurrent funding to support delivery of the early intervention in psychosis (EIP) standard;
- £10 million to support delivery of the new psychological therapies standards; and
- £30 million to support liaison psychiatry in acute hospitals.[12]

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9 See NHS Diagnostic Waiting Times and Activity Data Monthly Report: March 2014, page 3
10 Department of Health, The handbook to the NHS Constitution for England, July 2015, page 34
11 Gov.uk, First ever NHS waiting time standards for mental health announced, 8 October 2014

In 2014, the Department of Health and NHS England said that their ambition is for access and waiting time standards to be implemented for all mental health services over the next five years:

> Access and waiting time standards for treatment in physical health will be complemented by access and waiting time standards for mental health. Starting in some key areas next year, for the next five years the vision is for all mental health services to guarantee people access to timely, evidence-based and effective treatment. In doing so the NHS will not only shorten the time that people go without treatment and support, but also improve outcomes.[13]

For example, in 2014 the Government said it would like to see 95% of people referred to IAPT [Increasing Access to Psychological Therapies programme] to be treated within six weeks of referral, and would like to see rapid access to services within 24 hours for post-partum psychosis, in the perinatal period for women who have a mental health condition.[14]

In 2015, the Government said that as part of a £150 million investment for eating disorders over the next five years, waiting time standards for eating disorders will be set from 2016.[15] In July 2015, NHS England and the National Collaborating Centre for Mental Health published commissioning guidance on an *Access and waiting time standard for children and young people with an eating disorder*. The standard is for NICE recommended treatment to be received within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases. In cases of emergency, the eating disorder service should be contacted to provide support within 24 hours. Data collected in 2016 will help inform incremental percentage increases in compliance with the standard, with the aim of 95% of patients being treated within the standard's timescale by 2020.[16]

With regards to waiting time standards for children and young people's services, the Government have said that setting a blanket waiting time target for children and young people's mental health is not feasible due to the wide range of conditions and services this covers, all with very different care pathways. The Early Intervention in Psychosis waiting time applies to people of all ages, but most individuals experiencing a first episode of psychosis are in the 16-25 age range. Additionally, NHS England will be working with partner organisations to lead work on the development of further access and waiting time standards for children's mental health as part of the transformation programme on children and young people's mental health.[17]

1.4 GP appointments

In June 2010 the Government ended the central performance management of the target for access to primary medical care – seeing a professional within 24 hours and a GP within 48 hours – as part of its agenda to stop central performance management of process targets that it believed had limited justification.

In February 2015, Health Minister Dan Poulter outlined the Government's justification for abolishing the 48 hour target;

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12 PQ HL3514 [on Mental health services], 23 November 2015
13 Department of Health and NHS England, Achieving better access to mental health services by 2020, October 2014, page 11
14 Department of Health and NHS England, Achieving better access to mental health services by 2020, October 2014, page 18
15 HC Deb 3 March 2015 c914
16 PQ 16909 [on Mental health services: Children], 20 November 2015
17 PQ 16650 [on Mental health services: Children and young people], 20 November 2015

> The previous Government attempted to improve access to GP services by establishing a 48-hour access target. We know now that that target did not work. From 2007 to 2010, the proportion of patients who were able to get an appointment within 48 hours when they wanted one declined by 6%.
>
> A 48-hour target can make it more difficult for some of the more vulnerable patient groups who GPs look after, particularly people with complex medical co-morbidities, to get the important routine appointments that they need. We should bear in mind that targets can be perverse. That target did not work in its own right, and could make it more difficult for people with complex needs and the vulnerable and frail elderly to get the routine appointments that keep them well and properly supported in the community.[18]

The Conservative Party Manifesto 2015 also committed to ensuring everyone over 75 will get a same-day GP appointment if they need one.[19] Further information is available in the Library briefing on *General Practice in England* (May 2016).

1.5 New cancer waiting time standard

In July 2015, the Independent Cancer Taskforce published a five year strategy for the NHS, to improve cancer outcomes. The Taskforce recommended setting an ambition that by 2020, 95% of patients referred for testing by a GP are definitively diagnosed with cancer, or cancer is excluded, and the result communicated to the patient, within four weeks.

In September 2015, the Government responded to this recommendation and pledged that from 2020, people with suspected cancer will be diagnosed within 28 days of being referred by a GP.

The government also made a commitment that, by 2020, it will spend up to £300 million more on diagnostics every year to help meet the new 28 day target.[20]

The Government's *Mandate to NHS England 2016-17* states:

> A priority for NHS England will be to improve early diagnosis, services and outcomes for cancer patients, as outlined in Achieving World-Class Cancer Outcomes: A strategy for England 2015-20.[21]

1.6 Devolved administrations

In the NHS in Wales, no patient should wait more than 26 weeks from referral to elective/planned treatment. Some services are excluded from the 26 weeks target, including emergency care, mental health services and palliative care. There are also targets for cancer treatment: 62 days for an urgent suspected cancer and 31 days for a non-urgent suspected cancer referral.[22]

The NHS in Scotland has an 18 week maximum waiting time target from referral to elective/planned treatment.[23]

In Northern Ireland, at least 80% of patients should wait no longer than nine weeks for a first outpatient appointment, and no patient waiting longer than 15 weeks.[24]

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18 HC Deb 5 February 2015 c481-482
19 The Conservative Party Manifesto 2015, page 37
20 Department of Health, From 2020, people with suspected cancer will be diagnosed faster, 13 September 2015
21 Department of Health, The Government's mandate to NHS England for 2016-17, page 8
22 NHS Wales, RULES FOR MANAGING REFERRAL TO TREATMENT WAITING TIMES
23 The Scottish Government, 18 weeks RTT [last accessed 16 April 2015]
24 Department of Health, Social Services and Public Safety, Northern Ireland Waiting Time Statistics: Outpatient Waiting Times, Quarter Ending June 2014

2. Patient choice policies

The previous Labour Government developed a number of policies to strengthen patient choice within the NHS. Since January 2006, patients requiring a referral to a specialist for elective treatment have been entitled to a choice of at least four NHS hospitals through the "Choose and Book" system. From 2007 the Extended Choice Network allowed GPs to refer patients directly to the independent sector.

Since 2008, patients referred to a specialist by their GP have been able to choose treatment from any hospital listed in a national directory, which includes a number of independent sector providers. In 2009 the *NHS Constitution for England* made this a right for NHS patients. The policy was initially named "any willing provider", but was subsequently changed to "any qualified provider" to reflect the requirement that certain service standards must be met and the providers open to regulation by the Care Quality Commission (CQC).

The Coalition Government's *Programme for Government* (May 2010), set an ambition to further embed patient choice and put patients in charge of making decisions about their own care. The *Programme for Government* made specific commitments to patients being able to manage their own health records; introducing the right to register with any GP practice a patient wishes; and having the power to choose any healthcare provider that meets NHS standards, within NHS prices.[25]

2.1 Shared decision making

The *NHS Constitution for England* sets out patient rights to be involved in decisions about their care:

> You have the right to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate this right includes your family and carers.[26]

The principle of shared decision making was embedded in the Department of Health's White Paper: *Equity and Excellence: Liberating the NHS*. The paper stated in line with the principle of "no decision about me without me", shared decision-making should become the norm.

The paper set a series of objectives for the Coalition Government to realise its ambition of putting patients in charge of making decisions about their care:

> We will put patients at the heart of the NHS, through an information revolution and greater choice and control:
>
> a. Shared decision-making will become the norm: no decision about me without me.
>
> b. Patients will have access to the information they want, to make choices about their care. They will have increased control over their own care records.
>
> c. Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment. We will extend choice in maternity through new maternity networks.
>
> d. The Government will enable patients to rate hospitals and clinical departments according to the quality of care they receive, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.

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25 HM Government, The Coalition: Our Programme for Government, May 2010
26 NHS, The NHS Constitution for England, March 2013, page 9

> e. The system will focus on personalised care that reflects individuals' health and care needs, supports carers and encourages strong joint arrangements and local partnerships.
>
> f. We will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at national level, through a powerful new consumer champion, HealthWatch England, located in the Care Quality Commission.
>
> g. We will seek to ensure that everyone, whatever their need or background, benefits from these arrangements.[27]

These principles informed the *Health and Social Care Act 2012.*

The paper highlights that the NHS Commissioning Board (now NHS England) will be responsible for championing patient and carer involvement, and the Secretary of State will hold it to account for progress.[28]

The Government's *Mandate to the NHS 2015-16* highlighted that NHS England's objective is to ensure the NHS becomes dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment. The *Mandate* outlines the advantages that achieving this objective would bring:

- far more people should have developed the knowledge, skills and confidence to manage their own health, so they can live their lives to the full;
- everyone with long-term conditions, including people with mental health problems, should be offered a personalised care plan that reflects their preferences and agreed decisions;
- patients who could benefit should have the option to hold their own personal health budget as a way to have even more control over their care;
- the five million carers looking after friends and family members should routinely have access to information and advice about the support available – including respite care.[29]

2.2 Choice of provider

The *NHS Constitution* states that "You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs".[30]

Patients have the right to choose an organisation to provide NHS care when they are referred for their first outpatient appointment with a service led by a consultant:

> If you need to see a consultant or specialist as an outpatient for a physical or mental health condition, you can choose the organisation that provides your NHS care and treatment anywhere in England for your first outpatient appointment. (An outpatient appointment means you do not need to stay overnight).
>
> You can also choose which consultant-led team or which mental health team led by a named health care professional will be in charge of your NHS care and treatment (employed by the organisation you choose) for your first outpatient appointment.[31]

There are certain exceptions to this right:

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27 Department of Health, Equity and excellence: Liberating the NHS, July 2010, page 3
28 Department of Health, Equity and excellence: Liberating the NHS, July 2010, page 13
29 Department of Health, The Mandate: A mandate from the Government to NHS England: April 2015 to March 2016, December 2014, page 11
30 Department of Health, The Handbook to the NHS Constitution, 26 March 2013, p50
31 Department of Health & NHS, 2014/15 Choice Framework, April 2014, page 15

> **Persons excluded**
>
> persons detained under the Mental Health Act 1983
>
> serving members of the Armed Forces; and
>
> prisoners (including those on temporary release).
>
> **Services excluded**
>
> where speed of access to diagnosis and treatment is particularly important, e.g.:
>
> emergency attendances/admissions
>
> attendances at a Rapid Access Chest Pain Clinic under the two-week maximum waiting time, and
>
> attendance at cancer services under the two-week maximum waiting time
>
> maternity services
>
> mental health services; and
>
> public health services commissioned by local authorities.[32]

If a patient does not feel they have been offered a choice of hospital provider or consultant-led team within a hospital, they should discuss this with their GP. If they are still dissatisfied and feel they have not been offered choices, they could make a complaint to their local CCG.[33]

Transferring to a different hospital

It is possible to request to be referred to a different hospital following an initial outpatient appointment, if the patient is not satisfied with the initial provider. A new referral from the patient's GP must be sought. However, this may delay the treatment the patient needs, as a new 18 week maximum waiting time period will apply.[34]

Seeking a second opinion

NHS patients do not have an automatic right to a second or further opinion but doctors should always respect a patient's wish to obtain one and NHS Choices explains that a healthcare professional will rarely refuse to refer a patient for one. NHS Choices explains how patients can seek a second opinion

> If you would like a second opinion after receiving advice from your GP, you can ask them to refer you to another GP.
>
> Alternatively, you may consider asking to see a different GP at your surgery, if you're registered at a surgery with more than one GP, or changing to a different GP surgery.[35]

2.3 GP services

The Coalition Government's *Programme for Government* included an ambition for patients to have complete choice over their GP practice:

> We will give every patient the right to choose to register with the GP they want, without being restricted by where they live.[36]

There are catchment areas for GP practices, usually referred to as "practice boundaries", although practices do have discretion as to how rigidly they apply these. "Outer boundaries" were introduced in 2012 and were intended to allow registered patients who

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32 Department of Health, The Handbook to the NHS Constitution, 26 March 2013, p65
33 NHS Choices, Choosing a hospital [last accessed 4 February 2015]
34 NHS Choices, Choosing a hospital [last accessed 4 February 2015]
35 NHS Choices, How do I get a second opinion? [last accessed 16 April 2015]
36 HM Government, The Coalition: Our Programme for Government, May 2010, page 25

move outside the practice boundary but within the new outer boundary to remain registered with the same practice. Practices' outer boundaries should be advertised in practice leaflets and on websites and may also be made available on the NHS Choices website.

On 15 November 2013, NHS Employers and the BMA General Practitioners Committee (GPC) announced changes to the General Medical Services (GMS) contract in England for 2014/15. Changes included allowing GP practices to register patients from outside their practice boundaries. Further information is provided in a NHS Employers summary of the 2014/15 GMS contract:

> Choice of GP practice – from October 2014, all GP practices will be able to register patients from outside their traditional practice boundary areas without any obligation to provide home visits for such patients. NHS England will be responsible for arranging in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.

However, these new arrangements are voluntary for GP practices. If the practice has no capacity for new patients or feels it is not clinically appropriate for an individual to be registered so far away from home, they can then refuse registration.

2.4 Personal health budgets

A personal health budget is an agreed sum of money to support a person's identified health and wellbeing needs and provide services which have been planned and agreed by an individual, their representative, or, in the case of children, their families or carers, and the local NHS team. Personal health budgets are delivered by CCGs.

The national roll-out of personal health budgets began in November 2012. The results of a series of pilots found that personal health budgets led to an improved quality of life and a reduction in the use of unplanned hospital care.[37]

From April 2014, a legal "right to ask" for a personal health budget was introduced, which was extended to a legal "right to have" a personal health budget from October 2014, for adults receiving NHS Continuing Healthcare and children receiving Continuing Care.[38] The *NHS Mandate 2014-15* also set an objective for the NHS to further roll out personal health budgets to anyone who could benefit, by April 2015.[39]

NHS England highlights five key advantages to personal health budgets which support patient's having choice, control and flexibility over their care:

> Ideally, individuals or their representatives should:
>
> - Know upfront how much money they have available for healthcare and support.
> - Be enabled to choose the health and wellbeing outcomes they want to achieve, in dialogue with one or more healthcare professionals.
> - Be involved in the design of their care plan.
> - Be able to request a particular model of budget that best suits the amount of choice and control with which they feel comfortable.

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37 NHS England, Guidance on the "right to have" a Personal Health Budget in Adult NHS Continuing Healthcare and Children and Young People's Continuing Care, September 2014
38 Department of Health & NHS, 2014/15 Choice Framework, April 2014, page 14
39 Department of Health, The Mandate, A mandate from the Government to NHS England: April 2014 to March 2015, page 11

- Be able to spend the money in ways and at times that make sense to them, as agreed in their plan.[40]

There are three ways of delivering and managing a personal health budget. CCGs should make all three options available to allow people to make a choice about the level of control they feel comfortable with:

> Once you have a care plan agreed, you can manage your personal health budget in three ways, or a combination of these:
>
> - a 'notional budget': the money is held by your clinical commissioning group or other NHS organisation who arrange the care and support that you have agreed, on your behalf;
> - a 'third party budget': the money is paid to an organisation which holds the money on your behalf (such as an Independent User Trust) and organises the care and support you have agreed;
> - direct payment for health care: the money is paid to you or your representative. You, or your representative, buy and manage the care and services as agreed in your care plan. [41]

Patients receiving a personal health budget can choose to receive clinical services from any provider, including services that are not currently commissioned by a CCG or NHS England. This choice of service does not need to be agreed by an Independent Funding Review Panel, but must be approved by the CCG team responsible for approving the patient's personal health budget care plan.[42]

There are some services that direct payments cannot be used for. These include primary medical services provided by GPs; urgent or emergency treatment services; surgical procedures; and NHS charges such as prescription or dental charges.[43]

2.5 Mental health services

In April 2014, the Government introduced legal rights to patient choice in mental health for this first time. This was in line with the Government's ambition to achieve parity with physical health.[44]

The legal rights cover:

> If you need to see a consultant or specialist as an outpatient for a physical or mental health condition, you can choose the organisation that provides your NHS care and treatment anywhere in England for your first outpatient appointment. (An outpatient appointment means you do not need to stay overnight).
>
> You can also choose which consultant-led team or which mental health team led by a named health care professional will be in charge of your NHS care and treatment (employed by the organisation you choose) for your first outpatient appointment.[45]

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40 NHS England, Guidance on the "right to have" a Personal Health Budget in Adult NHS Continuing Healthcare and Children and Young People's Continuing Care, September 2014
41 NHS England, Guidance on the "right to have" a Personal Health Budget in Adult NHS Continuing Healthcare and Children and Young People's Continuing Care, September 2014
42 http://www.england.nhs.uk/wp-content/uploads/2014/12/choice-mhc-14.pdf page 35
43 For the full list, see NHS England, Guidance on Direct Payments for Healthcare: Understanding the Regulations, March 2014
44 Gov.uk, More choice in mental health, December 2012
45 Department of Health & NHS, 2014/15 Choice Framework, April 2014, page 4

In December 2014, NHS England published *Guidance on implementing patients' legal rights to choose the provider and team for their mental health care*. This is intended to help commissioners, GPs and providers support patients.

There are some exclusions that apply to these legal rights. These are where a patient is:

- already receiving mental health care following an elective referral for the same condition; or
- referred to a service that is commissioned by a local authority, for example a drug and alcohol service (unless commissioned under a Section 75 Agreement); or
- accessing urgent or emergency (that is, crisis) care; or
- accessing services delivered through a primary care contract; or
- in high secure psychiatric services; or
- detained under the Mental Health Act 1983; or
- detained in a secure setting. This includes people in or on temporary release from prisons, courts, secure children's homes, certain secure training centres, immigration removal centres or young offender institutions; or
- serving as a member of the armed forces (family members in England have the same rights as other residents of England).

2.6 Treatment in another European Economic Area country

Patients have the right to choose, subject to certain conditions, to receive treatment which is normally available to them on the NHS in other countries within the European Economic Area (EEA). This right is set out in the *NHS Constitution* and in EU Law:

> Under a new EU Directive on patients' rights in cross-border health care, you have the right to access any health care service in another Member State that is the same as or equivalent to a service that would have been provided to you in the circumstances of your case. This means that your treatment must be one that is available through the NHS.
>
> You then have a right to claim reimbursement up to the amount the treatment would have cost under the NHS - or the actual amount if this is lower. This means that you will normally have to pay for the full cost of your treatment upfront (though other arrangements may be available via your clinical commissioning group or NHS England).
>
> The Directive covers treatment provided in state-run hospitals and services provided by private clinics and clinicians. [46]

This Directive does not cover long-term care such as social care; access to and allocation of organs for transplantation; and public vaccination programmes against infectious disease.

Prior authorisation for treatment may be necessary before an individual can access treatment in another EEA country. If an individual is unable to access treatment on the NHS without undue delay in their particular case, they must be granted authorisation.[47]

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46 Department of Health & NHS, 2014/15 Choice Framework, April 2014, page 15
47 Department of Health & NHS, 2014/15 Choice Framework, April 2014, page 15

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